



GOVERNMENT
OF THE
DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
PHARMACEUTICAL CONTROL
717 14TH STREET, N.W., 6TH FLOOR
WASHINGTON, D.C. 20005
Telephone (202) 724-4900

**DRUG MANUFACTURE AND DISTRIBUTION
LICENSURE/REGISTRATION APPLICATION**

RETURN THIS COMPLETED APPLICATION AND FEE TO THE DEPARTMENT OF HEALTH. MAKE CHECK OR MONEY ORDER PAYABLE TO D.C. TREASURER.

CHECK ONE:

<input type="checkbox"/> MANUFACTURER	<input type="checkbox"/> REPACKAGER	<input type="checkbox"/> WHOLESALER	<input type="checkbox"/> DISTRIBUTOR
TYPE OF REGISTRATION	<input type="checkbox"/> NEW	<input type="checkbox"/> RENEWAL	<input type="checkbox"/> CHANGE OF OWNERSHIP

1. NAME OF COMPANY: _____
2. ADDRESS TO BE REGISTERED: _____

3. TELEPHONE NUMBER: () _____
4. IF RENEWAL, CERTIFICATE NUMBER _____
5. NAME AND RESIDENT ADDRESS OF RESPONSIBLE COMPANY OFFICIAL: _____

6. MAILING ADDRESS (IF DIFFERENT FROM ITEM #2): _____

7. OWNERSHIP: ☐ PROPRIETORSHIP ☐ PARTNERSHIP/JOINT
 ☐ CORPORATION VENTURE
8. LIST IN SPACE (PROVIDED ON OTHER SIDE) NAME AND RESIDENT ADDRESS FOR THE FOLLOWING:
 - A. PROPRIETORSHIP-PROPRIETOR
 - B. PARTNERSHIP-ALL PARTNERS
 - C. CORPORATION-OFFICERS AND RESPONSIBLE OFFICIAL AT REGISTERED ADDRESS

9. FOR IN-STATE APPLICANTS THAT ARE CORPORATIONS, THE NAME AND ADDRESS OF EACH OFFICER OR DIRECTOR OF THE CORPORATION, AND THE NAME OF THE STATE OF INCORPORATION IF OTHER THAN THE DISTRICT OF COLUMBIA.
10. HAS THE APPLICANT OR ANY OTHER LISTED ON THE APPLICATION EVER BEEN CONVICTED OR A FELONY RELATED TO DRUGS UNDER THE D.C., STATE, OR FEDERAL LAW, OR EVER SURRENDERED OR HAD A CONTROLLED SUBSTANCES APPLICATION REGISTRATION REVOKED, SUSPENDED, OR DENIED? IF THE APPLICANT IS A CORPORATION, ASSOCIATION, PARTNERSHIP, HAS ANY OFFICER, PARTNER, STOCKHOLDER OR PROPRIETOR BEEN CONVICTED OF A FELONY RELATING TO DRUGS UNDER D.C., STATE, OR FEDERAL LAW OR EVERY SURRENDERED OR HAD A CONTROLLED SUBSTANCES APPLICATION REGISTRATION REVOKED, SUSPENDED OR DENIED?

IF THE ANSWER TO EITHER QUESTION IS YES, INCLUDE A STATEMENT USING THE SPACE PROVIDED BELOW:

11. TYPE OF DRUGS: ☐ PRESCRIPTION ☐ OTC ☐ VET OTC
☐ VET PRESCRIPTION ☐ CONTROLLED SUBSTANCES
(AS DEFINED BY FEDERAL LAW/DEA)
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APPLICANT'S EXPLANATION TO QUESTION 7, 8 OR 9 (IF APPLICABLE):

I CERTIFY THAT ALL OF THE STATEMENTS MADE BY ME ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND ARE MADE IN GOOD FAITH.

APPLICANT'S NAME

TITLE

DATE

APPLICANT'S SIGNATURE